

**PATIENT INFORMATION**

**PLEASE PRINT**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone (\_\_\_\_) \_\_\_\_\_ work phone (\_\_\_\_) \_\_\_\_\_ Cell (\_\_\_\_) \_\_\_\_\_

Patient SS# \_\_\_\_\_ Spouses Name \_\_\_\_\_

**GUARANTOR INFORMATION**

**PERSON RESPONSIBLE**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

SS# \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Employer Name \_\_\_\_\_

Employer Address \_\_\_\_\_

Work Phone (\_\_\_\_) \_\_\_\_\_ Extension/Dept. \_\_\_\_\_

**Circle one:** Spouse    Parent    Guardian    Other \_\_\_\_\_

**INSURANCE INFORMATION**

Insurance Name: \_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_ Referred By: \_\_\_\_\_

Employer: \_\_\_\_\_

ID# \_\_\_\_\_ **E mail Address:** \_\_\_\_\_

**HEALTH HISTORY**

- |   |     |    |
|---|-----|----|
| 1. Have you been seen by a physician during the past year?            | YES | NO |
| 2. Are you presently under medical care or taking any medicine?       | YES | NO |
| 3. Have you ever had a prolonged illness or Hospitalization?          | YES | NO |
| 4. Have you ever had surgery or X-Ray Therapy?                        | YES | NO |
| 5. Have you ever had any of the following diseases?                   |     |    |
| • Rheumatic Fever.....  | YES | NO |
| • Jaundice ___Hepatitis ___(yellow skin or eyes).....                 | YES | NO |
| • Epilepsy___ Seizures_____.....                                      | YES | NO |
| • Sugar Diabetes.....   | YES | NO |
| • High Blood Pressure___ Low Blood Pressure _____.....                | YES | NO |
| • Kidney Trouble .....  | YES | NO |
| • Heart Trouble-_____Heart Attack_____.....                           | YES | NO |
| • Venereal Disease.....   | YES | NO |
| • Thyroid Disease .....   | YES | NO |
| • Tuberculosis.....   | YES | NO |
| • AIDS.....   | YES | NO |
| • Other_____.....   | YES | NO |
| 6. Have you lost weight without dieting in the last few months? ..... | YES | NO |
| 7. Have you ever been sick from a shot for dental treatment?          | YES | NO |
| 8. Have you or any relative had any bleeding problem? .....           | YES | NO |
| 9. Have you ever had serious bleeding after a tooth extraction? ..... | YES | NO |

